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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a routine health resurvey and complaint investigations #60527 and #60608. | F 000 | | |
| F 252 SS=C | 483.15(h)(1)<br>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT<br><br>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 44 residents. Based on observation and interview, the facility failed to provide a homelike environment,related to broken dining tables in the dining room of the facility.<br><br>Findings included:<br><br>- Observation, on 10/1/12 at 12:00 PM, identified the dining area of the facility contained 5 tables. Four of those 5 tables exhibited a veneer edge surrounding the rectangular table top, with various broken and missing pieces, ranging in sizes from 1 inches to 6 inches.<br><br>Interview, on 10/3/12 at 9:30 AM with dietary staff B, indicated the remodel plan for the facility contained plans to replace the existing tables.<br><br>The facility failed to provide a clean, homelike, and comfortable dining room, when 4 of the 5 tables in the dining room exhibited broken veneer | F 252 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F 252 | Continued From page 1<br>edging to the tables. | F 252 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 44 residents with 16 selected for sample review. Based on observation, interview, and record review, the facility failed to develop an individualized plan of care for 1 of 16 sampled residents, ( # 26) related to sleep hygiene.<br><br>Findings included:<br><br>- Per the facility face sheet, the facility admitted | F 279 | | |

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| F 279 | Continued From page 2 | F 279 | | |

resident #26 on 8/27/12.

The resident's 9/4/12 physician's order sheet identified a diagnosis of insomnia, the inability to sleep or remain asleep, and noted an order for Ambien, a hypnotic, 10 milligrams, by mouth, every night, for 6 months, ordered on admission, 8/27/12.

The 9/6/12 admission MDS (minimum data set) identified the resident with a BIMS (brief interview of mental status) score of 15/15, indicating intact cognition. The assessment further identified the resident exhibited behaviors and mood of feeling tired, having trouble concentrating, lacked identification of any wandering tendencies and used medications of anti-psychotics, anti-depressants and sedative/hypnotics.

A 8/27/12, sleep evaluation identified the resident reported having difficulty with staying asleep, denied a history of any sleep related disorder, reported a history of using sleep medications and continued with a current medication, denied that lack of sleep affected the resident's daily functioning, consumed soft drinks that might affect the resident's sleep habits, smoked cigarettes, reported exercising 1-3 days per week, denied napping during the day, used anti-depressant medication that could affect sleep habits, experienced psychological issues that could affect sleep habits, unable to identify any environmental factors that might affect sleep and indicated staff needed to encourage limiting caffeine after mid- day.

Review of the care plan, initiated 9/10/12, lacked any interventions related to the use of a

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| F 279 | Continued From page 3<br>scheduled sleep aide, or instructing staff in the resident's sleep hygiene needs.<br><br>Nursing notes, dated 9/28/12 at 3:45 AM, documented: "The resident up most of the night. ...Nurse reminded [the] resident had taken Ambien and needed to go to bed...resident wanted a cigarette. CNA (certified nurse aide) took [the] resident out to smoke."<br><br>On 10/1/12 at 2300 (11:00 PM) nursing notes documented, the resident in bed with eyes closed. Had paced almost constantly this evening, in halls. Took all medications, except sleeping medication.<br><br>On 10/2/12 at 2250 (10:50 PM) nursing notes documented, the resident had taken sleeping medication, and leaned on the nurses desk almost the entire shift, making requests of the staff.<br><br>On 10/4/12 at 10:55 AM, licensed nursing staff C, reported the staff conducted a sleep evaluation for the resident upon admission, related to the sedative/hypnotic order, however, failed to address the sleep hygiene interventions in the resident's plan of care.<br><br>The facility failed to develop an individualized plan of care for the resident requiring a sedative/hypnotic on a daily basis, to include non-pharmacological interventions to aide in promoting a normal sleep pattern for this resident. | F 279 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS | F 329 | | |

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| F 329 | Continued From page 4<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 44 residents, with 10 residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility to ensure 3 of these 10 sampled residents freedom from unnecessary medications including; 2 sampled residents (#1 and #26) lacked blood pressure parameters to direct staff when to withhold the medication and 1 sampled resident (#7) lacked blood sugar parameters to direct staff when to notify the | F 329 | | |

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| F 329 | Continued From page 5<br>physician of low and/or high blood sugar reading.<br><br>Findings included:<br><br>- Review of resident #1's face sheet revealed staff admitted the resident to the facility on 2/25/09.<br><br>On 7/28/11, the resident's physician ordered staff to check the resident's blood pressure weekly, on Wednesdays.<br><br>On 8/2/11, the resident's physician ordered Lisinopril 10 mg (milligrams), daily, for hypertension.<br><br>The resident's 8/28/12 quarterly MDS (Minimum Data Set) recorded the resident as rare/never understood, independent with decision making skills, and indicators of delirium of disorganized thinking.<br><br>The resident's 7/31/12 care plan recorded the pharmacist needed to review the medications monthly and to take medications as ordered.<br><br>Review of the resident's 7/12 MAR (Medication Administration Record) revealed staff administered to the resident, on a daily basis, the Lisinopril for hypertension. Review of the 7/12 TAR (Treatment Medication Administration) revealed the resident refused her blood pressure readings taken by the staff.<br><br>Review of the resident's 8/12 MAR revealed staff administered to the resident, on a daily basis, the Lisinopril for hypertension. Review of the 8/12 TAR revealed staff obtained weekly blood | F 329 | | |

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| F 329 | Continued From page 6 | F 329 | | |

pressure readings, and on 8/22/12, the resident's blood pressure reading was 95/73. Staff recorded the resident refused blood pressure readings taken the other 4 times during the month of 8/12.

Review of the resident's 9/12 MAR revealed staff administered to the resident, on a daily basis, the Lisinopril for hypertension. Review of the 9/12 TAR revealed staff obtained weekly blood pressure readings, and on 9/26/12, the resident's blood pressure reading was 94/57.

Review of the resident's drug regimen review revealed no irregularities identified for the drug reviews conducted on 7/24/12, 8/24/12, and 9/18/12.

On 10/3/12 at 8 AM, observation revealed the resident in the living area talking in a loud voice. At 8:45 AM, after breakfast the resident walked down the hall, still talking in a loud voice.

On 10/3/12 at 10:38 AM, observation revealed the resident continued to speak in a loud voice in the hallways.

On 10/3/12 at 2 PM, administrative licensed staff A verified the facility lacked a policy for blood pressure parameters to direct staff when to withhold the administration of blood pressure medications.

On 10/3/12 at 2:14 PM, licensed staff D stated, "I would hold the resident's blood pressure medication if the systolic was below 100 or the diastolic was below 60."

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On 10/4/12 at 12:20 PM, consultant staff E stated, "I watch residents who are on blood pressure meds [medications], monitoring their blood pressures within normal ranges for several times upon admission. After that monitors periodically if stable. Not aware there were not any parameters established for staff to hold and/or notify physician of blood pressure readings."

The facility failed to ensure the resident free from unnecessary medications, as the facility lacked a policy or physician's order to inform staff of blood pressure parameters and direct staff as to when the resident's blood pressure medications needed held.

- Per the facility face sheet, the facility admitted resident # 7 on 6/30/04, and with a diagnosis including Insulin Dependent Diabetes Mellitus.

The quarterly MDS (minimum data set), dated 7/16/12, identified a BIMS (brief interview of mental status) score of 15/15, indicating intact cognition. The mood and behavior sections of the MDS indicated the resident felt tired, and experienced hallucinations and delusions at times.

The 8/11/11 care plan lacked instructions to staff related to the residents blood glucose (sugar) or blood pressure monitoring.

A physician's order summary identified the physician ordered "Accuchecks," (blood glucose monitoring), four times daily, three times weekly, on 7/28/11, related to a diagnosis of diabetes

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| F 329 | Continued From page 8<br>mellitus, with medications of:<br><br>Novolog, 17 units, once daily before lunch, subcutaneous injection, ordered on 9/1/11.<br>Novolog, 12 units, once daily in the AM, by subcutaneous injection, ordered on 12/19/11.<br>Novolog, 30 units, once daily with supper, by subcutaneous injection, ordered 6/24/11.<br>Lantus, 27 units, once daily at bedtime, by subcutaneous injection, ordered 6/24/11.<br><br>The order lacked parameters for notification of the physician related to high or low blood sugar levels.<br><br>Review of the residents blood glucose (sugar) monitoring for September 2012, identified the following concerns:<br><br>1. On 8/7/12 at 1330 (1:30 PM) the staff recorded a blood sugar of 308, without indication the staff notified the physician regarding the elevation in blood sugar.<br><br>2. On 8/28/12 at 1330 (1:30 PM) the staff recorded the residents blood sugar at 67, the flow record indicated the staff provided "Ensure," and identified the staff failed to notify the physician and further failed to monitor the resident for followup regarding the low blood sugar reading.<br><br>On 10/3/12 at 2:00 PM, interview with administrative nursing staff A, reported the facility lacked a policy for blood sugar monitoring, and stated, "We just follow the physician's orders, and use nursing judgement." Further review, at that time, lacked identification of parameters for physician notification related to blood sugar | F 329 | | |

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| F 329 | Continued From page 9<br>monitoring.<br><br>On 10/3/12 at 10:35 AM licensed nursing staff D, reported the facility lacked parameters for notification of residents having high or low blood sugars, and nursing staff, "Just give the resident's a snack if the resident's blood sugar is below 70. If it is high then we just monitor them. We don't have any parameters, really, just kind of use the standard guidelines."<br><br>A request for policies and procedures related to monitoring of blood sugars, identified a lack of policy.<br><br>The facility failed to consistently monitor the resident's blood sugar to ensure the resident received the necessary care and services associated with high/low blood sugars and failed to ensure the resident remained free of unnecessary drugs.<br><br>- Per the facility face sheet, the facility admitted resident # 26 on 8/27/12.<br><br>The physician's order sheet, dated 9/4/12, identified a diagnosis of hypertension and an order for Propranolol HCL, 20 mg (milligrams), daily, ordered 8/27/12 and included instructions to check the resident's blood pressure prior to administration.<br><br>The 9/6/12 admission MDS (minimum data set) identified the resident with a BIMS (brief interview of mental status) score of 15/15, indicating intact cognition. | F 329 | | |

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| F 329 | Continued From page 10 | F 329 | | |

The resident's care plan, dated 9/10/12, lacked instructions regarding the need for daily blood pressure monitoring, related to the administration of a daily blood pressure medication.

Review of the September, 2012, and October, 2012, MAR/TAR (medication administration record/treatment administration record) failed to identify daily blood pressure monitoring, as ordered. The records indicated the resident's Propranolol administered daily, except when the resident out of the facility.

On 10/3/12 at 2:00 PM, administrative nursing staff A, reported, "We [the facility] don't have a policy or established parameters for blood pressure monitoring."

Interview on 10/3/12 at 2:14 PM, with licensed nursing staff D, indicated, "I would hold the resident's blood pressure medication if the resident's diastolic measured below 60 or the systolic measured less than 100. I just use nursing judgment."

On 10/4/12 at 10:52 AM, licensed nursing staff D, reported a lack of awareness the resident required blood pressure monitoring, daily.

On 10/4/12 at 10:55 AM, licensed nursing staff C, reported the resident's blood pressure should be monitored every day, per the physician's order, however, did not located in the clinical record, that staff monitored the resident's blood pressure daily.

The facility failed to provide a policy for the

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| F 329 | Continued From page 11<br>monitoring of blood pressure monitoring and parameters.<br><br>The facility failed to monitor the resident's blood pressure daily, as ordered, prior to administration of the physician's ordered anti-hypertensive medication, and to ensure the resident remained free of unnecessary medications. | F 329 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 44 residents, with 10 residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility's consultant pharmacist failed to identify drug irregularities for 3 of these 10 sampled residents including; 2 sampled residents (#1 and #26) lacked blood pressure parameters to direct staff when to withhold the medication and 1 sampled resident (#7) lacked blood sugar parameters to direct staff when to notify the physician of low and/or high blood sugar reading.<br><br>Findings included: | F 428 | | |

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- Review of resident #1's face sheet revealed staff admitted the resident to the facility on 2/25/09.

On 7/28/11, the resident's physician ordered staff to check the resident's blood pressure weekly, on Wednesdays.

On 8/2/11, the resident's physician ordered Lisinopril 10 mg (milligrams), daily, for hypertension.

The resident's 8/28/12 quarterly MDS (Minimum Data Set) recorded the resident as rare/never understood, independent with decision making skills, and indicators of delirium of disorganized thinking.

The resident's 7/31/12 care plan recorded the pharmacist needed to review the medications monthly and to take medications as ordered.

Review of the resident's 7/12 MAR (Medication Administration Record) revealed staff administered to the resident, on a daily basis, the Lisinopril for hypertension. Review of the 7/12 TAR (Treatment Medication Administration) revealed the resident refused her blood pressure readings taken by the staff.

Review of the resident's 8/12 MAR revealed staff administered to the resident, on a daily basis, the Lisinopril for hypertension. Review of the 8/12 TAR revealed staff obtained weekly blood pressure readings, and on 8/22/12, the resident's blood pressure reading was 95/73. Staff recorded the resident refused blood pressure

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| F 428 | Continued From page 13 | F 428 | | |

readings taken the other 4 times during the month of 8/12.

Review of the resident's 9/12 MAR revealed staff administered to the resident, on a daily basis, the Lisinopril for hypertension. Review of the 9/12 TAR revealed staff obtained weekly blood pressure readings, and on 9/26/12, the resident's blood pressure reading was 94/57.

Review of the resident's drug regimen review revealed no irregularities identified for the drug reviews conducted on 7/24/12, 8/24/12, and 9/18/12.

On 10/3/12 at 8 AM, observation revealed the resident in the living area talking in a loud voice. At 8:45 AM, after breakfast the resident walked down the hall, still talking in a loud voice.

On 10/3/12 at 10:38 AM, observation revealed the resident continued to speak in a loud voice in the hallways.

On 10/3/12 at 2 PM, administrative licensed staff A verified the facility lacked a policy for blood pressure parameters to direct staff when to withhold the administration of blood pressure medications.

On 10/3/12 at 2:14 PM, licensed staff D stated, "I would hold the resident's blood pressure medication if the systolic was below 100 or the diastolic was below 60."

On 10/4/12 at 12:20 PM, consultant staff E stated, "I watch residents who are on blood pressure meds [medications], monitoring their

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blood pressures within normal ranges for several times upon admission. After that monitors periodically if stable. Not aware there were not any parameters established for staff to hold and/or notify physician of blood pressure readings."

The facility's consultant pharmacist failed to identify this irregularity, as the facility lacked a policy or physician's order to ensure staff informed of blood pressure parameters and direct staff as to when the resident's blood pressure medications needed held.

- Per the facility face sheet, the facility admitted resident # 7 on 6/30/04, and with a diagnosis including Insulin Dependent Diabetes Mellitus.

The quarterly MDS (minimum data set), dated 7/16/12, identified a BIMS (brief interview of mental status) score of 15/15, indicating intact cognition. The mood and behavior sections of the MDS indicated the resident felt tired, and experienced hallucinations and delusions at times.

The 8/11/11 care plan lacked instructions to staff related to the residents blood glucose (sugar) or blood pressure monitoring.

A physician's order summary identified the physician ordered "Accuchecks," (blood glucose monitoring), four times daily, three times weekly, on 7/28/11, related to a diagnosis of diabetes mellitus, with medications of:

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Novolog, 17 units, once daily before lunch, subcutaneous injection, ordered on 9/1/11.
Novolog, 12 units, once daily in the AM, by subcutaneous injection, ordered on 12/19/11.
Novolog, 30 units, once daily with supper, by subcutaneous injection, ordered 6/24/11.
Lantus, 27 units, once daily at bedtime, by subcutaneous injection, ordered 6/24/11.

The order lacked parameters for notification of the physician.

Review of the residents blood glucose (sugar) monitoring for September 2012, identified the following concerns:

1. On 8/7/12 at 1330 (1:30 PM) the staff recorded a blood sugar of 308, without indication the staff notified the physician regarding the elevation in blood sugar.

2. On 8/28/12 at 1330 (1:30 PM) the staff recorded the residents blood sugar at 67, the flow record indicated the staff provided "Ensure," and identified the staff failed to notify the physician and further failed to monitor the resident for followup.

On 10/3/12 at 2:00 PM, interview with administrative nursing staff A, reported the facility lacked a policy for blood sugar monitoring, and stated, "We just follow the physician's orders, and use nursing judgement." Further review, at that time, lacked identification of parameters for physician notification related to blood sugar monitoring.

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On 10/3/12 at 10:35 AM licensed nursing staff D, reported the facility lacked parameters for notification of residents having high or low blood sugars, and nursing staff, "Just give the resident's a snack if the resident's blood sugar is below 70. If it is high then we just monitor them. We don't have any parameters, really, just kind of use the standard guidelines."

On 10/4/12 at 12:20 PM, interview with consulting pharmacist staff E, identified the consulting staff monitored blood sugars on a routine basis, during the monthly visits.

A request for policies and procedures related to monitoring of blood sugars, identified a lack of policy.

The facility consultant pharmacist failed to identify the facility's lack of established blood sugar parameters to consistently monitor the resident's blood sugar to ensure the resident received the necessary care and services associated with high/low blood sugars and to ensure the resident remained free of unnecessary drugs.

- Per the facility face sheet, the facility admitted resident # 26 on 8/27/12.

The physician's order sheet, dated 9/4/12, identified a diagnosis of hypertension and an order for Propranolol HCL, 20 mg (milligrams), daily, ordered 8/27/12 and included instructions to check the resident's blood pressure prior to administration.

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The 9/6/12 admission MDS (minimum data set) identified the resident with a BIMS (brief interview of mental status) score of 15/15, indicating intact cognition.

The resident's care plan, dated 9/10/12, lacked instructions regarding the need for daily blood pressure monitoring, related to the administration of a daily blood pressure medication.

Review of the September, 2012, and October, 2012, MAR/TAR (medication administration record/treatment administration record) failed to identify daily blood pressure monitoring, as ordered. The records indicated the resident's Propranolol administered daily, except when the resident out of the facility.

On 10/3/12 at 2:00 PM, administrative nursing staff A, reported, "We [the facility] don't have a policy or established parameters for blood pressure monitoring."

Interview on 10/3/12 at 2:14 PM, with licensed nursing staff D, indicated, "I would hold the resident's blood pressure medication if the resident's diastolic measured below 60 or the systolic measured less than 100. I just use nursing judgment."

On 10/4/12 at 10:52 AM, licensed nursing staff D, reported a lack of awareness the resident required blood pressure monitoring, daily.

On 10/4/12 at 10:55 AM, licensed nursing staff C, reported the resident's blood pressure should be monitored every day, per the physician's order, however, did not located in the clinical record,

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| F 428 | Continued From page 18<br>that staff monitored the resident's blood pressure daily.<br><br>On 10/4/12 at 12:20 PM, interview with consulting pharmacist staff E, identified the consulting staff monitored residents receiving anti-hypertensives closely for normal limits, upon admission. The staff further added, "If they [the resident] remain stable for several months, then I don't monitor the blood pressures, as closely." The consultant staff failed to identify on the 9/18/12 pharmacy review, the facility failed to monitor the resident's blood pressures, as ordered.<br><br>The facility consultant pharmacist failed to identify the facility's failure to monitor the resident's blood pressure daily, as ordered, prior to administration of the physician's ordered anti-hypertensive medication, and to ensure the resident remained free of unnecessary medications. | F 428 | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. | F 431 | | |

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| F 431 | Continued From page 19<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 44 residents. Based on observation, interview, and record review of 1 of 1 medication rooms, the facility failed to ensure the medications maintained in the medication room remained with a label identifying the prescription, with the correct dosage, route and resident, and remained free of expiration.<br><br>Findings included:<br><br>- Observation on 10/1/12 at 9:30 AM, identified a locked medication room, with a separate locked area for narcotics lockup. Observation of the medications contained in the lockup area included four cards of unlabelled (without a resident's name), Clozapine, with 3 of the cards expired, as follows: | F 431 | | |

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| F 431 | Continued From page 20<br><br>1. Clozapine, 200 mg (milligrams), 8 tablets, expired on 9/30/12.<br><br>2. Clozapine, 200 mg, 6 tablets, expired on 9/30/12.<br><br>3. Clozapine, 100 mg, 34 tablets, 1 partially opened/punched out from the bubble pack.<br><br>4. Clozapine 100 mg, 5 tablets, 1 tablet partially opened/punched out from the bubble pack, and expired on 7/31/12.<br><br>Interview, with licensed nursing staff C, on 10/1/12 at 9:30 AM, reported the medications had been in the locked cabinet since the staff began working at the facility (a couple of months ago). The staff reported, the medications had been saved from resident's that left the facility and did not return, during a time, when the pharmacy experienced a shortage of Clozaril the facility kept the medication to ensure that residents who needed (had prescriptions) Clozaril, lacked accessibility to it. The staff reported, "I'm not sure why they (the Clozaril) were never destroyed," and indicated they would not be acceptable to use for the residents.<br><br>Interview, on 10/4/12 at 9:44 AM, with licensed nursing staff A, reported, "I intend to trash them (the Clozaril) now, but we didn't want our residents to run out. At the time we kept them (the Clozaril) it was because of the shortage of Clozaril. We now have an emergency backup with our pharmacy. I know we can't dispense medications, that's the pharmacy's job." | F 431 | | |

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| F 431 | Continued From page 21<br>At 9:48 AM on 10/4/12, administrative nursing staff A and licensed nursing staff C, reported the Clozaril had been destroyed.<br><br>Review of the facility policy, dated 5/1/10, identified as, "Omnicare, Inc. 8.2 Disposal/Destruction of Expired or Discontinued Medication," included, "...4. Facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction."<br><br>The Omnicare, Inc. policy, dated 5/10/10, titled 5.3 Storage and Expiration of Medications, Biological's, Syringes and Needles, included, "...6. Facility should destroy and reorder medications and biological's with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels."<br><br>The facility failed to ensure the facility medication room remained free of expired and unlabelled medications. | F 431 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections | F 441 | | |

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| F 441 | Continued From page 22<br>in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 44 residents with 16 selected for sample review. Based on observation, interview, and record review, the facility failed to ensure 7 resident's, including 2 sampled residents (#7 and 54) reviewed for blood sugar monitoring with a multi-resident use glucometer, received appropriate services for sanitizing and disinfecting the glucometer, as required. Additionally, the facility failed to ensure | F 441 | | |

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staff remained free of open skin lesions, uncovered, while providing dining services for residents, during the dining process on 1 of 1 observations.

Findings included:

- The facility reported 7 resident's required blood sugar monitoring through use of a multi use glucometer machine.

Observation, on 10/1/12 at 10:15 AM, identified licensed nursing staff C, conducted a blood sugar check on resident #7. The staff set up the equipment on a multi-use tray.

Following the blood sugar check, staff C cleansed the glucometer, as well as the tray the glucometer rested on, with an 70% isopropyl alcohol pad. At that time, staff C stated, "I have used the alcohol wipes since starting here, about 3 weeks ago. They (alcohol wipes) are easy and accessible."

At 10:20 AM, Staff C conducted a blood sugar check on resident #54, after cleansing the unit with the alcohol wipe.

The facility policy, "Cleaning the Meter," undated, indicated, "If the meter gets dirty, use a moist (NOT WET) lint-free cloth dampened with a mild detergent."

An additional policy, dated August, 2010, for "Cleaning and Disinfection of Resident-Care Items and Equipment," included a Policy Statement: "Resident-care equipment, including reusable items and durable medical equipment

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| F 441 | Continued From page 24<br>will be cleansed and disinfected according to current CDC (Center for Disease Control) recommendations for disinfection and the OSHA (Occupations and Safety Health Administration) Bloodborne Pathogens Standard."<br><br>The Centers for Disease Control and Prevention (CDC), 2003-2004, Transmission of Hepatitis B virus among persons undergoing glucose monitoring in long term care facilities, included, "...If glucometers must be shared,...ensure that staff always clean and disinfect (eg. using a 1 to 10 diluted bleach solution) the device between patients..."<br><br>The facility failed to ensure adequate sanitizing and disinfecting of the glucometer meter, as required, for the 7 reported residents, requiring glucometer checks.<br><br>- Observation on 9/30/12 at 12:05 PM in the main dining room of the facility identified dietary staff B, setting up the dining area, with utensils, cups and glasses. Observation, at that time, identified the staff exhibited several uncovered open skin lesions to the staffs forearms.<br><br>Interview, on 10/3/12 at 2:30 PM, with an alert resident indicated a concern in the dining room where a staff member exhibited open wounds to their forearms and assisted with meals.<br><br>On 10/3/12 at 4:17 PM, administrative staff G, reported, "I'm looking into getting a chef's jacket for the staff member the resident is referring to."<br><br>The facility failed to ensure residents remained | F 441 | | |

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| F 441 | Continued From page 25<br>free from contact with staff members with open skin lesions in relation to food service. | F 441 | | |
| F 463 SS=C | 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH<br><br>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 44 residents, all identified as independently mobile with ambulation. Based on observation and interview, the facility failed to ensure a call system that accurately notified staff of the residents' bathroom locations.<br><br>Findings included:<br><br>- Observation during stage one of the survey, on 10/2/12 from 8:00 A.M. - 9:00 A.M., test of call lights revealed the following:<br><br>The shared bathroom call light for rooms 1/2, showed room 27 on the call light panel at the nurses station.<br><br>The shared bathroom call light for rooms 3/4, showed room 28 on the call light panel at the nurses' station.<br><br>The shared bathroom call light for rooms 5/6, showed room 31 on the call light panel at the nurses' desk. | F 463 | | |

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| F 463 | Continued From page 26<br>The shared bathroom call light for rooms 7/8, showed room 33 on the call light panel at the nurses' desk.<br><br>The shared bathroom call light for rooms 9/10, showed room 35 on the call light panel at the nurses' desk.<br><br>The shared bathroom call light for rooms 11/12, showed room 37 on the call light panel at the nurses' desk.<br><br>The shared bathroom call light for rooms 13/14, showed room 39 on the call light panel at the nurses' desk.<br><br>The single bathroom call light for room 15, showed room 41 on the call light panel at the nurses' desk.<br><br>The shared bathroom call light for rooms 17/18, showed room 44 on the call light panel at the nurses' desk.<br><br>The shared bathroom call light for rooms 19/20, showed room 45 on the call light panel at the nurses' desk.<br><br>The shared bathroom call light for rooms 21/22, showed room 46 on the call light panel at the nurses' desk.<br><br>The shared bathroom call light for rooms 23/24, showed room 47 on the call light panel at the nurses' desk.<br><br>The shared bathroom call light for rooms 25/26, showed room 48 on the call light panel at the | F 463 | | |

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| HAVILAND CARE CENTER LLC | 200 MAIN HAVILAND, KS 67059 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 463 | Continued From page 27<br>nurses' desk.<br><br>During the environmental tour, on 10/3/12 from 1:30 P.M. to 3:00 P.M., housekeeping/maintenance/laundry staff F reported that he/she didn't know anything about the call system, or why the bathroom emergency light came up on the nursing station call board with different room numbers than the resident rooms.<br><br>On 10/3/12 at 3:00 P.M., administrative staff G, reported staff used the over door lights to determine when a resident required assistance and did not know anything about different room numbers lighting on the call board. Administrative staff G reported, the facility currently getting a bid this day for replacement of the call system.<br><br>On 10/4/12 at 10:00 A.M., consultant staff L, reported he/she unaware of any problem with the facility call system.<br><br>The facility failed to ensure a call system that accurately documented the location of the activated emergency call from resident bathrooms. | F 463 | | |
| F 518 SS=C | 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS<br><br>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.<br><br>This REQUIREMENT is not met as evidenced | F 518 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E038 | A. BUILDING _____ B. WING _____ | 10/08/2012 |

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|---|---|---|---|---|
| F 518 | Continued From page 28 | F 518 | | |

by:
The facility identified a census of 44 residents. Based on interview and record review, the facility failed to ensure staff obtained the required training for emergency preparedness

Findings included:

- On 10/3/12 at 10:00 A.M., housekeeping/maintenance/laundry staff J, reported and explained facility training for threats of fire and tornado evacuation. Continued interview with housekeeping/maintenance/laundry staff J, revealed he/she unaware of the protocol for bomb threats or chemical spills.

On 10/3/12 at 10:30 A.M., dietary staff K reported he/she received training for fire emergencies, however, had not received any training for tornado warnings, bomb threats or chemical spills.

On 10/3/12 at 3:00 P.M., housekeeping/maintenance/laundry staff F reported the procedure for fire and tornado warnings. He/she continued unaware of protocol for bomb threats or chemical spills.

On 10/3/12 at 3:45 P.M., direct care staff I reported the correct procedure for fires, tornado warnings, chemical spills, and missing residents, however continued that he/she unaware of what to do if the facility received a bomb threat.

On 10/3/12 at 4:00 P.M., administrative staff H, reported that facility staff received inservice training through the Silverchair learning on the computer.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 518 | Continued From page 29<br><br>Review of the compliance report computer print out from 9/1/11 through 9/30/12, documented 2 of 28 staff completed the emergency preparedness training that included fire, tornadoes, missing residents, bomb threats and chemical spills.<br><br>On 10/4/12 at 12:30 P.M., administrative staff G, reported as part of training requirements, staff are to read the disaster planning book that included procedures for emergency preparedness. Administrative staff G revealed no inservice presentations in addition to the Silverchair computer assignments.<br><br>On 10/4/12 at 12:30 P.M., consultant staff L reported that the corporation assigned the Silverchair learning, and that each facility manages individual staff compliance of the training.<br><br>The facility failed to ensure all staff received periodical review of procedures for emergency preparedness that included missing residents, bomb threats, tornado drills and chemical spills. | F 518 | | |